3 Ambulatory Surgical Center Guidelines

3.1 Introduction

3.1.1 General Policy

This section addresses all Medicaid-covered services provided in an ambulatory surgical center (ASC) as deemed appropriate by Medicaid. Section 3 presents information on the following topics as they relate to ASC services:

- Electronic and paper claims billing
- Claims payment
- Prior authorization
- Nursing technician and related services
- Use of ASC facilities

NOTE: Most transplant services are not covered for **CHIP-B** participants.

Refer to the **CHIP-B Appendix section B.1.5** for service limitations for **CHIP-B** participants.

3.1.2 Covered Services

ASC facility services generally include:

- Drugs, biologicals, surgical dressings, supplies, splints, casts, implants, appliances, and equipment directly related to the provision of surgical procedures
- Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure
- Administration, record keeping, and housekeeping items and services
- Materials for anesthesia
- Implants which provide a biomedical function such as an artificial joint, pins, screws, and plates which are not routine supplies, may be billed in addition to the procedure code(s) by specifying the HCPCS code which describes the implant.

  The ASC facility must enroll as a Durable Medical Equipment (DME) provider. See **Section 3.1.4, Payment**, for additional information.

  Only the following codes are separately billable. Bill the appropriate HCPCS with the ASC facility's DME provider number on a separate CMS-1500 claim form.

L0100-L0174	L3650-L3860
L0180-L0220	L3900-L6693
L0450-L0860	L6700-L8049
L0960-L0984	L8300-L8510
L0999-L1499	L8606
L1500-L1990	L8619
L2000-L2090	L9900
L2106-L2116	
L2126-L2999	
L3224-L3225	

- Corneal Tissue: processing, preserving, and transporting (HCPCS V2785) is a covered benefit when the ASC facility purchases the tissue. Invoice for the purchase of the corneal tissue must be attached to the CMS-1500 claim form.

3.1.3 Non-covered Services

ASC facility services do **not** include the following:

- Physician services
- Laboratory services, x-ray, or diagnostic procedures, other than those directly related to the performance of the surgical procedure
- Prosthetic and orthotic devices
- Ambulance service
- Durable medical equipment for use in the client's home
- Any other service not specified in the *Rules Governing the Medical Assistance Program* (IDAPA 16.03.09.121.04.b)
- Procedures appropriately performed in a physician's office or in an inpatient setting of an acute hospital

3.1.4 Payment

Medicaid reimburses ASCs for procedures on a fee-for-service basis using a single fee under the surgical code. Usual and customary fees are paid up to the Medicaid maximum allowance. ASCs must bill using the same procedure codes used by the performing physician.

ASC facility service payments represent reimbursement for the costs of goods and services recognized by the Medicaid program as described in the Idaho Administrative Procedures Act (IDAPA 16.03.09.121.03). Medicaid pays at the rate levels established by Medicaid (IDAPA 16.03.09.121.04.a).

ASCs are paid 100 percent of the established rate for the first procedure and 50 percent for any remaining procedures. If the procedure is a unilateral code, and there is no other code for the other parts, such as 28126 (resection, single toe, each) or 28153 (resection, head of phalanx, toe), it may be billed as many times as anatomically appropriate. In this example, 10 times.

Any Medicaid payment must be accepted as payment in full for Medicaid covered services. The client cannot be billed for the difference between the billed amount and the Medicaid reimbursed amount.

ASCs may arrange for private payment with families for non-covered services (the family should be made informed prior to services being performed that this is a non-covered service).

When an ASC facility bills separately for an implant, they must do the following:

- Bill on a separate CMS-1500 claim form from the surgical procedure
- Report with their DME provider number
- Check eligibility to see if the client is enrolled in Healthy Connections, Idaho's Medicaid managed care program. If a client is enrolled, there are guidelines that must be followed to ensure

reimbursement for providing Medicaid-covered services. Refer to Section 1.5, Healthy Connections, of the provider handbook for the Healthy Connections guidelines. All inpatient and outpatient hospital services and ancillary providers must have a referral from the Healthy Connections primary care provider in order to be reimbursed.

3.1.5 Prior Authorization

Submit prior authorization requests with appropriate documentation to:

Division of Medicaid
Surgery Authorizations
P.O. Box 83720
Boise, ID 83720-0036

NOTE: EDS is not an authorizing agency for any Medicaid services and does not issue prior authorization.

See Section 2.3.2 for more information on electronically billing services that require prior authorization.

3.1.6 Place of Service Code

ASC services can only be billed for in the following place of service:

24 — Ambulatory Surgical Center

Enter this information in field 24B on the CMS-1500 claim form, or in the appropriate field of the electronic claim.

3.2 Ambulatory Surgery Policy

3.2.1 Surgical Procedures

3.2.1.1 Abortions

Medicaid will only cover a legal therapeutic abortion in order to save the life of the mother or in cases involving rape or incest.

Medicaid will pay in cases of rape or incest, as determined by a court or reported to a law enforcement agency. A copy of the court determination or documentation of the report to law enforcement may be attached to the claim to expedite payment. If the rape or incest was not reported to law enforcement, a licensed physician or osteopath must certify in writing that, in his/her professional medical opinion, the woman was unable to report the rape or incest to law enforcement for reasons related to her health. The certification must contain the name and address of the woman. When determination of the rape is based on age, the certification must show that the woman was under 18 at the time of the sexual intercourse.

When a pregnancy is life threatening, Medicaid will cover an abortion to save the life of the woman. One licensed physician or osteopath must certify in writing that the woman may die if the fetus is carried to term. The certification must contain the name and address of the woman.

3.2.1.2 Hospitalization

Hospital charges for a therapeutic abortion are subject to the same restrictions as the physician's/osteopath's charges. The physician/osteopath should send a copy of the properly completed Certification of Necessity form to the hospital with the client. The hospital is required to attach a copy of the form to their claim.

3.2.1.3 Exception

Medicaid does not pay for any type of abortion for clients on the Presumptive Eligibility (PE) program. In addition, PE clients are not covered for delivery services.

3.2.1.4 How to Obtain a Certification of Necessity Form

To receive a Certification of Necessity form, call EDS at:

383-4310
from the Boise calling area, or

1-800-685-3757
outside the Boise calling area

The automated system is available 24 hours a day. Customer service is available Monday through Friday (excluding holidays) from 8 a.m. - 6 p.m. MST

3.2.1.5 Sample Certification of Necessity for Abortions

I, _____(name of physician/osteopath),

attending physician/osteopath to _____(name of client) certify that in my professional judgment, allowing this client's present pregnancy to be carried to term will endanger her life.

Date _____

Signature of Physician/Osteopath _____

Name of client _____

Address of client _____

3.2.1.6 Dilation and Curettage

All dilation and curettage (D & C) procedures require documentation in the form of an operative report, Emergency Department report, or office notes. Please attach required documentation to claim for submission.

3.2.1.7 Hysterectomy

Approval from the QIO (Quality Improvement Organization), known as Qualis Health, must be obtained and the prior authorization number entered on the claim form in field 23 of the CMS-1500 claim form.

Medicaid pays for hysterectomies if the *Authorization for Hysterectomy* form is attached to the claim. Outpatient hysterectomy claims are subject to Idaho Medicaid Medical Consultant review.

The *Authorization for Hysterectomy* form may be signed either before or after the surgery has been performed. If the form is signed after the surgery has been performed, the client must sign a statement clearly stating that she was informed, both verbally and in writing, before the surgery was performed, that the hysterectomy would render her sterile.

3.2.1.8 Sample Authorization for Hysterectomy

I have been informed orally and in writing that the hysterectomy will render me permanently incapable of reproducing. I was informed of these consequences prior to the surgery being performed.

Signature: _____

Date: _____

3.2.2 Dental Procedures

Dental procedures performed in an ASC do not require prior authorization. Use procedure code **41899** for all dental procedures performed in an ASC. CPT **41899** is payable at ASC Level 3.

3.2.3 Ambulatory Surgical CPT Codes

See the Department of Health and Welfare Website for a complete listing of approved ambulatory surgical CPT codes and payment levels. The site is

available at:
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/ASC%20Codes%20as%20of%202-03-05.pdf

Consult your CPT manual for complete descriptions of the codes.

3.3 Claim Form Billing

3.3.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other vendor compliant software.

To submit electronic claims, use the HIPAA-compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

All claims must be received within one year of the date of service.

3.3.2 Electronic Claims

For PES software billing questions, consult the Idaho PES Handbook. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

In addition to new HIPAA-required fields, the changes listed in Guidelines for Electronic Claims are effective October 20, 2003.

3.3.2.1 Guidelines for Electronic Claims

See **Section 2** for more information on electronic billing.

Detail lines
Idaho Medicaid allows up to **50** detail lines for electronic HIPAA 837 Professional claims.

Referral number
A referral number is required on an electronic HIPAA 837 Professional claim when a client is referred by another provider. Use the referring provider's Medicaid provider number, unless the client is a Healthy Connections client. For Healthy Connections clients, enter the provider's Healthy Connections referral number.

Prior authorization (PA) numbers
Idaho Medicaid allows more than one prior authorization number on an electronic HIPAA 837 Professional claim. PAs can be entered at the header or detail of the claim.

Modifiers
Up to **4** modifiers per detail are allowed on an electronic HIPAA 837 Professional claim.

Diagnosis codes
Idaho Medicaid allows up to **8** diagnosis codes on an electronic HIPAA 837 Professional claim.

Electronic crossovers
Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

3.3.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms (formerly known as the HCFA 1500) to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2005 is entered as 07/04/2005

3.3.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MM/DD/CCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed.
- Do not use staples or paperclips for attachments. Stack the attachments behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

3.3.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
P.O. Box 23
Boise, ID 83707

3.3.3.3 Completing Specific Fields on the Paper Claim Form

EDS denies incomplete claims, so make every effort to provide valid, complete information as specified on the claim form.

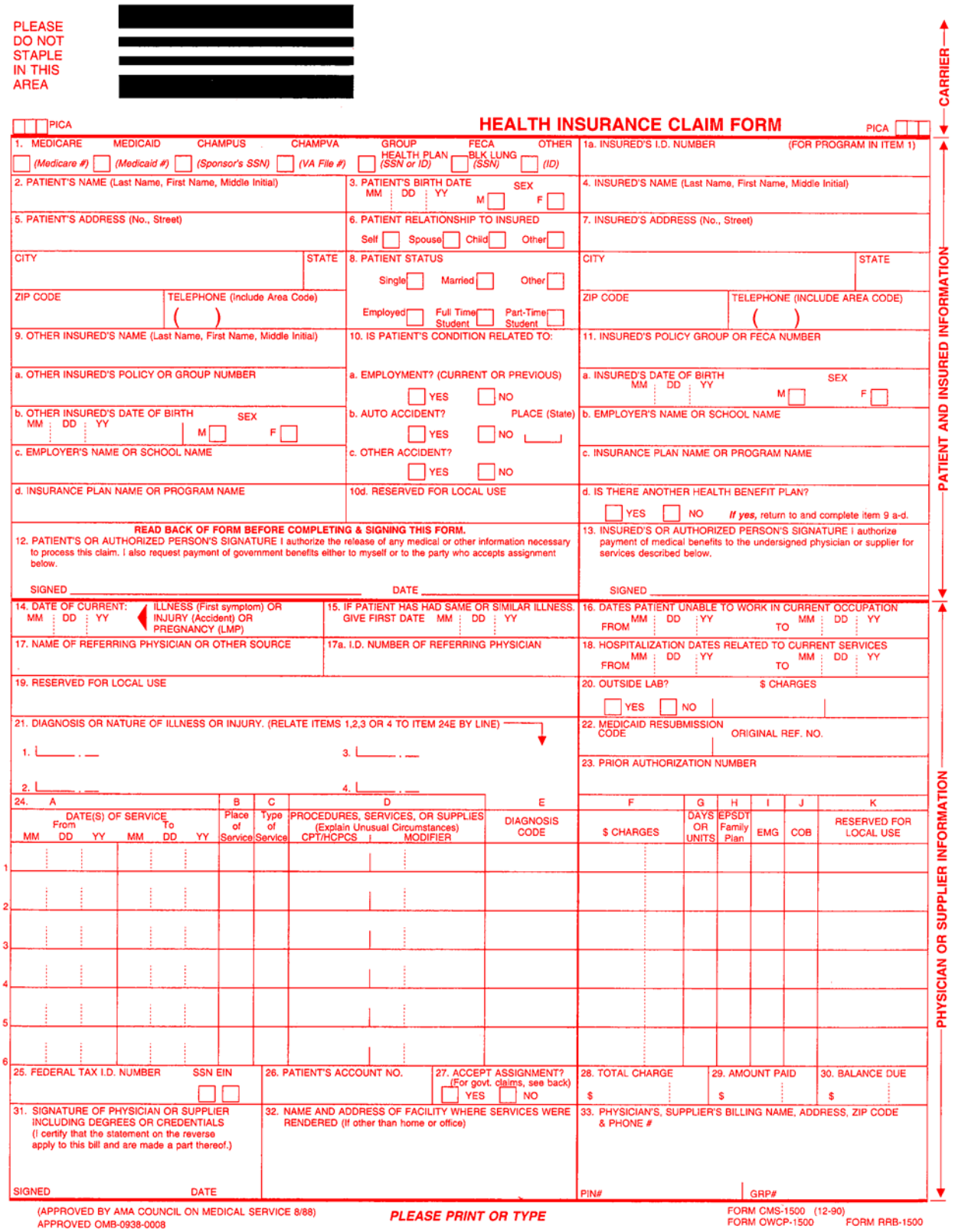
The following numbered items correspond to the CMS-1500 claim form and includes only those fields that are required for Medicaid billing. Claim processing will be delayed when required information is not entered into any required field.

Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the seven-digit client ID number exactly as it appears on the plastic client ID card.
2	Patient's Name	Required	Enter the client's name exactly as it appears on the Medicaid plastic ID card. Be sure to enter the last name first, followed by the first name and middle initial.

Field	Field Name	Use	Directions
9a	Other Insured's Policy or Group Number	Required if applicable	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the policy and group number.
9d	Insurance Plan Name or Program Name	Required if applicable	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate yes or no if this condition is related to the client's employment.
10b	Auto Accident?	Required	Indicate yes or no if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate yes or no if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check yes or no if there is another health benefit plan. If yes, return to and complete items 9a-9d.
17	Name of Referring Physician or Other Source	Required if applicable	Use this field when billing for a consultation or Healthy Connections client. Enter the referring physician's name.
17a	ID Number of Referring Physician	Required if applicable	Use this field when billing for a consultation or Healthy Connection client. Enter the referring physician's Medicaid provider number. For Healthy Connections clients, enter the provider's Healthy Connections referral number.
19	Reserved for Local Use	Required if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. Use this field to enter ICN of previous claim(s) to document timely filing for claim resubmission.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to 4) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required if applicable	If applicable, enter the prior authorization number from Medicaid, DHW, RMS, ACCESS, RMHA, EDS, Quality Improvement Organization (QIO), or MTU.
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). **Example:** November 24, 2005 becomes 11242005 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24D 1	Procedure Code Number	Required	Enter the appropriate five-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as three. Otherwise, leave this section blank.

Field	Field Name	Use	Directions
24E	Diagnosis Code	Required	Use the number of the subfield (1-4) for the diagnosis code entered in field 21.
24F	Charges	Required	Enter your usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H1	EPSDT (Health Check) Screen	Required if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen, refer to the instructions for EPSDT claims in the provider handbook.
24K	Reserved for Local Use	Required if applicable	When a group, agency, or clinic is the billing agency, enter the Idaho Medicaid provider number of the individual provider rendering the service in Field 24K and the group provider number in field 33.
28	Total Charge	Required	Add the charges for each line then enter the total amount.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach EOB from other insurance company showing payment or denial, reason codes (with an explanation of codes), and the date the claim was processed.
30	Balance Due	Required	Enter the total charges, less amount entered in amount paid field.
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See **Section 1.1.4** for more information.
33	Provider Name and Address	Required	Enter your name and address exactly as it appears on your provider enrollment acceptance letter or RA. If you have had a change of address or ownership, please, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33	PIN# or GRP#	Required	Enter your nine-digit Medicaid provider number. If payment is to be made to a group, enter the Idaho Medicaid group number in GRP# space and individual provider number in field 24K. See **Section 2.2.3.1** for more information.

3.3.3.4 Sample Paper Claim Form



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statement on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500